



# RENDERING PROVIDER FORM

Mail to: Department of Mental Health  
Chief Information Office Bureau  
Systems Access Unit  
695 South Vermont Avenue  
Los Angeles, CA 90005

## Request Type

Submit Date

☐ New

☐ Update

License  
Reporting Unit  
Effective Date

☐ Terminate

☐ Name Change

## General Information

Last Name:

First Name:

Middle Initial:

Sex: M F

Ethnicity

DMH/NGA Staff Code

FFS Ind Prov No.

SSN (Last 4 only)

Language Code

Select DMH Classcode:

☐ DMH

Prov name:

☐ DHS

Prov name:

☐ Non-Governmental Agency (DMH Contracted)

L.E. #:

L.E. Name:

☐ FFS Individual

☐ FFS Group

☐ FFS Org

Tax Payer ID

(FFS only)

## Contact & Assigned Location Information

Contact name:

Contact Email:

Contact phone no: ( )

Contact Fax No: ( )

☐ Add this rendering provider in the service location indicated below: (please use form MH-228A for additional locations)

☐ Delete this rendering provider in the service location indicated below. ☐ Delete this rendering provider in ALL service locations within the legal entity indicated above.

DMH/NGA Prov No./Rept Unit

FFS Group/Org Prov No.

(Please enter the provider no. associated to the above taxpayer ID)

Effective  
Date

Termination  
Date

Locum Tenum

Intern

Name of Organization:

Service Area

MHSA

Address:

City:

Zip:

## Taxonomy and License Information (Required if request type is NEW)

Description:

Taxonomy

Professional  
License #

Effective  
Date

Expiration  
Date

Description:

Taxonomy

Professional  
License #

Effective  
Date

Expiration  
Date

DEA  
License #

Expiration Date

Medicare Prov No.  
(DMH directly-operated only)

PPIN Medicare No.  
(DMH directly-operated only)

Expiration  
Date

NPI

NPI Effective Date

Authorized Manager/Designee

Signature:

Print Name:

Date:

## CIOB USE ONLY

Rendering Provider IS No:

Ticket #

Date Processed

Processed by: